PHYSICIANS, PATIENTS & POWER:

A Micro-analysis

of the

Physician/Patient Encounter

by

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CHAPTER I: STATEMENT OF PROBLEM AND NEED FOR PRESENT STUDY

> "When the final pages of history are written, each nation will be judged according to how it has taken care of its sick and its old. We can be proud that the people of this great country of ours receive the best medical care in the world. Our health care system works and we must guard against the threat of government interference" (Schroeder, 1979).

These words were part of a recent address to the community by a local physician. Meanwhile, an editorial in the Journal of the American Medical Association calls for political awakening and unity among physicians (Callan, 1979:1498), while still another editorial in the prestigious New England Journal of Medicine argues against the idea of medical care as a right (Scully, 1980:245). Members of the powerful American medical profession see themselves under attack, and the American health care system which historically has been the exclusive domain of physicians, is being challenged.

Despite America's claim to be the standard bearer of human rights, health care reform in the United States has lagged behind such reform in many other Western industrialized countries (Scully, 1980:244). President Jimmy Carter has declared that "they (doctors) have been the major obstacle to progress in our country in having a better health care system . . ." (Hexson, 1978:35). Senator Edward Kennedy has "condemned doctors as businessmen and not healers" (Haycock, 1978:483).

It is a point of fact that the American health care system which began as a cottage industry built upon the ideals of liberalism and

individualism has been transformed into a multi-billion dollar "medical-industrial complex," which in 1976 produced a total output of over $139 billion--over 8.6 per cent of the gross national product (McKinlay, 1977:462). This medical-industrial complex is controlled by the medical profession, and Eliot Freidson (Freidson, 1977:485) suggests "that (this) professional dominance is the analytical key to the present inadequacy of health services."

Now, for the first time in American history, the public, the government and health care consumers are challenging this system and its professional dominance. But, strategies for change, such as federal and state regulations, patient advocacy programs, health systems agencies and professional standards review organizations are all aimed at the system in an attempt to increase the access, availability, and distribution of health care. These strategies, like the proposed national health insurance, may impact the system, but the power to control the quality of American health care remains with the physician as long as he controls the physician/patient relationship.

In fact, it has been suggested that health care systems changes "may increase the possibility that everyone will receive the type of impersonal uncaring care now reserved for the poor" (Scully, 1980: 249). It is predictable that creating a still larger structure for health care will increase the already patriarchal nature of the practice of medicine in this country. This has been the experience of other American institutions, and there is no reason to believe that this would not be true of a health care system that is presently characterized as autocratic and coercive, and that reduces patients to a state of helplessness and subordination to the physician.

A great deal has already been written about the patriarchal nature of American medicine and the following are but a few illustrations. Phyllis Chesler (Chesler, 1971:376) has described the role of the physician as one that "fosters submission, dependency and infantilism in the patient" and implies "ommiscient and benevolent superiority" on the part of physicians. Michael Balint (Anderson, 1979:260) has described the "apostolic function of the physician" in which the physician sees as his "duty to convert to his faith all the ignorant and unbelieving among his patients," and Szasz and Hollander (Anderson, 1979:260) have analyzed the physician/patient relationship as varying stages of the parent/child type of relationship. These few examples are typical of the existing critiques of the present practice of medicine.

It is predictable that "changes in the structure of health care will have little impact without changed attitudes on the part of providers" (Scully, 1980:249). In order for real change to occur, there must be "equality in patient/provider relationships" (Scully, 1980: 250). The public may be moving toward control of the system, but significant changes in American health care will occur only when the patient has some power and control in the physician/patient encounter.

This study specifically addresses that problem and will focus on the power relationships that develop during the physician/patient encounter. It will examine the "power process" of the encounter by observing and analyzing the behavior of the participants to determine if this behavior in fact constructs a power advantage for the physician and how this behavior operates to designate control of the en-

counter. It will examine what variables are associated with the differential ability of patients to define and control their situations, and will attempt to prove that in some situations the power differential is so great that it precludes any legitimate negotiation between the participants. A micro-study of the physician/patient encounter such as this promises to reveal the emerging process of reality definition that results from the behavior of the participants.

The underlying assumption of this study is that social interaction is dynamic and that differentials exist that cause the interaction to be dynamic and to vary. It is the purpose of this study to suggest that physicians and patients behave in differing ways according to these variables. This examination will include the concept of role and will attempt to evaluate how this concept impinges upon the physician/patient encounter, but it is the purpose of this study to suggest that too much emphasis has been placed on role theory and not enough on behavior as a result of social interaction.

This analysis is an attempt to contribute to a new understanding of the physician/patient relationship. It may, in turn, generate further research and it may help to lead the way toward strategies that will encourage equality in that relationship. Without this equality, there can be no significant change in the health care of this nation.

Need for Present Study

The evidence suggests that a microscopic analysis of the physician/ patient encounter is both needed and appropriate if strategies for change are to be developed that will impact the American health care system.

Symbolic-interactionism is a micro-theory and will be used as the theoretical perspective for this study. Symbolic-interactionism concerns itself with the microscopic analysis of interaction and its developmental character (Glazer & Strauss, 1964:678). It provides an appropriate framework because its methodological position is that social action must be studied in terms of how it is formed (Blumer, 1969:57). Symbolic interactionism is an interpretive or cognitive approach that subscribes to the theory that inidividuals define each situation and then subsequently construct their action. It is founded upon the idea of reality negotiation between participants and denies the traditional sociological approach that individuals learn roles and act accordingly in a given situation.

All of the analyses of the physician/patient encounter found in the literature and recorded here imply a need for future research of this kind. Barney G. Glazer and Anselm M. Strauss (Glazer & Strauss, 1964:678) specifically advocate more microscopic analysis of interactional behavior and its developmental character. Joan Emerson's (Emerson, 1975:75) study of patient/physician interaction during the gynecological examination led her to conclude that symbolic interactionism provides a "framework for making sense of social interaction" and that these situations are precarious and differ in how much effort it takes for an individual to sustain their reality. Her

study implies the need for future research to critically examine the interactional process of such efforts. David Hayes-Bautista's (Hayes-Bautista, 1976:223-238) illuminating studies suggest that the refusal of medical professionals to be more aware of the needs of health care consumers mandate that "the whole notion of client control in a patient/practitioner interaction must be carefully examined and the requisite theoretical properties developed." As a result of their study of walk-in clinics, Sherman Eisenthal and Aaron Lazare (Eisenthal & Lazare, 1976:739-748) see future research in this area as a major step in a process culminating in negotiation between the clinician and the patient over treatment dispositions.

The negotiation process according to symbolic-interactionist theory implies common knowledge between the participants. This is simply not the case in the physician/patient relationship. The evidence shows that the physician has the power advantage to control the encounter and the exchange of knowledge. In order for negotiation to occur, this framework suggests that "all corpuses of knowledge can be, indeed must be, appropriated with equal respect however systemically organized. This means that the conventional distinction between science and non-science cannot be seriously entertained and a reconceptualization of science is made possible" (Beng-Huat Chua, 1974:245). Using the symbolic interactionist framework for the analysis of the physician/patient encounter assumes prospects that are revolutionary. Shared knowledge concerning health care is the first step toward radical change in our health care system. Symbolic interactionism implies shared knowledge and does not accept "normal practice" as a given and as "an essential regulatory concept

in sociology," it makes it a topic of inquiry and this makes it subject to change (Beng-Huat Chua, 1974: 24). This evidence suggests that the symbolic-interactionist framework appears especially appropriate for this study.

W. Timothy Anderson and David Helm (Anderson & Helm, 1976: 260) as well indicate that there has not been enough analysis of the "mundane, taken-for-granted interactional components which have a profound impact on the interaction and outcome of the (physician/ patient) encounter." The indication here is that the implications for change as a result of such a study are considerable.

Symbolic-interactionism promises change. It has been described as "the most significant development in sociological thinking in recent years" because it is a "radical break from standard sociology" and is "potentially revolutionary" in its implications (Morris, 1975:171). It implies that members of society do not have to accept their roles in a docile manner. If social structures appear solid, it is only because people believe that they are solid and unchangeable. Symbolic-interactionism has the potential to demonstrate that these structures can be challenged. "Human social order is ultimately a symbolic reality that exists only as long as it is believed in and changes as people struggle to shift those beliefs to their own advantage" (Morris, 1975: 172). Sociologists must consider the liberating effects that this could have when people begin to realize just how this operates.

> The dramaturgical view of society, that social reality requires a script, actors, body idioms, ethos, involvement, norms, clearance norms, relevance rules, conventions . . . has political payoffs . . . the script for reality may take the stage--given adequate political means . . . (Morris, 1975:171).

Given this perspective, the study of the physician/patient relationship necessarily precludes any political changes in the American health care system. Since research within the symbolic interactionist framework can be directed toward identifying ways in which those labeled and dominated can resist or counter such a process (Morris, 1975:177), this study could develop into a body of knowledge that would be just the kind of knowledge the patient needs to address the problem of physician dominance. As C. Wright Mills has indicated "the center of truthfulness lies in individual subjectivities rather than in the objective network of institutions" (Morris, 1975:175).

All the analyses of the physician/patient encounter recorded here imply a quest for dominance. Additionally, Howard Waitzkin and John Stoeckle (Anderson & Helm, 1979:261) have viewed the relationship as a micropolitical system in which the physician uses the control of information to maintain dominance and subordination. How this power process develops and works to give the physician this power advantage must be critically analyzed. This study of the behavior of the participants in the physician/patient encounter and how that behavior operates in the "power process" of the encounter specifically addresses the documented need for additional research.

Focal Questions and Definitions of Terms

This study of physicians, patients and power will seek to answer the following focal questions:

1. What variables are associated with the differential ability of patients to construct their reality?

2. Is there a difference in the behavior of physicians relating to patients based upon sex differences?

3. Does the disproportionate power advantage that the physician holds over the patient limit any legitimate negotiation of the reality of the surgical experience?

4. Do preoperative patients perceive that they will have control over their situation? Is this perception altered following the surgical experience?

5. Does the behavior of patients demonstrate that they seek to control their situation?

These issues are concerned with the process of power nd need clarification if we are to understand the power advantage of the physician, the control the physician exercises over the surgical experience of the patient, and the patient's acceptance of physician dominance. These issues necessitated selection of both male and

female patients who were about to enter into the surgical experience and who could be followed through their initial encounter with the physician and their discharge from the hospital.

For the purposes of this study, the following will be used as operational definitions of terms:

Power - the ability to control the decisions and activities of another person by imposing one's will upon their behavior.

Authority - power that is legitimized because persons agree that those occupying a given status may exercise power over them.

Control - the power or authority to guide and manage the behavior of another.

Professional Dominance - power granted to those who occupy the status of expert and that implies the right to command and a duty to obey.

Social Interaction - behavior oriented in its course to the behavior of other persons (Weber).

Physician/ Patient Encounter - temporary social interaction between a physician and a patient.

Reality - phenomena that we recognize as having a being independent of our own volition and that corresponds to known facts (Berger & Luckmann).

Reality Construction - the process by which knowledge is developed, transmitted and maintained through social interaction so that a taken-for-granted reality is created for an individual (Berger & Luckmann).

Reality Negotiation - the ability of an individual to influence the formation of what is real and meaningful to him/her and of that which impinges upon his/her life experiences.

Gestures - any aspect of an ongoing action that signifies the larger act of which it is a part (Mead).

Role - behavioral expectations of a position.

CHAPTER II: METHODOLOGY OF STUDY

Procedure

This study was conducted in a large, inner-city, teaching hospital. Twenty-one surgical patients were interviewed preoperatively. The interaction between these patients and their physicians was observed during the initial physician/patient encounter. These same patients were interviewed postoperatively upon discharge from the hospital. The participating physicians were interviewed following each patient's discharge.

Patient interviews included the identification of variables that were anticipated to impact the physician/patient encounter. These variables were age, sex, race, marital status, educational history, work history and past experiences with hospitalization and physicians. Both male and female patients were interviewed and observed.

Observation of behavior noted the gestures of the participants and included attention to language, posturing, names, symbols, eye contact, touch, clothing, conversation, space, sense of involvement and commitment to task at hand, body movements such as shrugs, and facial expressions such as frowns, smiles, etc. Research measures also included examination of patient records and simple behavior observation of hospital staff at work.

Preoperative and postoperative interviews with patients provided comparative data on the power perceptions of patients. According to Norman K. Denzin (Denzin, 1970:131), social acts have a beginning, in which persons imagine how they're going to act, a middle phase in

which they actually act, and a phase in which they terminate their action. Preoperative interviews, observation of physician/patient encounters and discharge interviews provided comparative data for each of these three distinct phases of the patient social action.

The patients studied were selected on the basis of their availability to be interviewed and observed during their initial encounter with their physician. This necessitated a close monitoring of the operating schedules and the admissions of patients to the hospital. Preoperative patients at this medical center are routinely admitted to the hospital in the late afternoon of the day preceding their surgery. The initial physician/patient encounter generally occurs at unscheduled times during the evening of admission. Typically, the physician visit is anticipated, but unpredictable, thus heightening the anxiety of the normally apprehensive patient and increasing the power advantage of the physician. Occasionally, it was noted that the physician simply did not visit the patient preoperatively. This supports Anderson and Helm's (Anderson & Helm, 1979:262) contention that the physician sees the patient on his terms, at times and places that are convenient to him.

These unscheduled physician visits increased the degree of difficulty in the selection of the patient sample. Patient selection was dependent upon the availability of newly admitted patients whose physicians chose to make their preoperative visits at a time when he and the patient could be observed by the researcher. Obviously, the patient sample was signficiantly influenced by chance which meant that the data collection was considerably more time-consuming than anticipated. These difficulties as well as time constraints upon the

researcher significantly influenced the sample size of this study.

It is relevant to note that physician approval, not patient permission, had to be obtained in order to observe the encounter. Patient permission was, of course, sought prior to the patient interviews.

Patient Sample

Of the twenty-one patients studied, 76.2% were female. The average age of the subjects was 39.8 years with the youngest being 18 years old and the oldest 88 years old. Fifty-seven percent of the subjects were white and 43% black. The marital status showed 71.1% married, 4.7% widowed, 9.5% divorced, and 14.7% single. The educational background of the subjects reflected that 51.3% had completed high school, 19.2% had completed college and 28.5% had completed grade school. The employment status was 66.6% employed with the 33.4% unemployed including a student, a retiree and five housewives. The employed were 10 factory workers, two office workers, one self-employed and one salesperson. Sixty-two percent of the females studied were employed, while 80% of the males studied were employed.

The operations for which the subjects were scheduled were as follows: 87.5% of the female patients were scheduled for gynecological procedures, 50% of which had sterilizations as either a primary or secondary procedure. Only two other operations, a cholecystectomy and a herniorrhaphy, were scheduled for the female patients studied. The male patients were scheduled for a cholecystectomy, circumcision, cystoscopy, appendectomy and the removal of a bullet.

Gender Pronouns

A clarification concerning the gender of pronouns is indicated. Because women are the majority of health care consumers in a male-dominated health care system and because the majority of the subjects of this study were female and all of the physicians were male, the feminine pronoun is used to refer to the patient and the masculine

pronoun is used to refer to the physician. The male pronoun will be used generically when referring to the theoretical construct.

CHAPTER III: SURVEY OF LITERATURE

The Social Reality of the Hospital

The hospital has increasingly become the centrally most important setting for the provision of medical care in American society (Georgopoulous, 1979:295). It is being used as the organizational setting for the examination of the physician/patient encounter because it most profoundly illustrates the social construction of a new reality for the patient. Indeed, it has been suggested that "becoming a hospital patient is similar to entering a foreign nation" (Denton, 1978:149).

The hospital as a social organization has considerable impact upon the physician/patient encounter. Organizational structures typically impact upon the social interaction that occurs within them. The social organization enters into the action to the extent to which it shapes situations in which people act, and to the extent to which it supplies fixed sets of symbols which people use in interpreting their situation (Blumer, 1969: 88).

Anderson and Helm (Anderson & Helm, 1979:259) support the notion that the organizational setting of the hospital sets the tone for the physician/patient encounter. They argue that the interests, rules and concerns of the organization favor the physician, but in spite of this they still suggest that the encounter is a process of reality negotiation between the two principals. Their work has been extremely useful and enlightening. This study will, however, critically examine their assertion that reality is negotiable in this encounter. In order to do this, it is essential to first of all understand the

social organization of the hospital.

Hospitals are almost uniformly regarded as unpleasant places to be. The hospital, as a total institution, creates a depersonalizing environment that forces the patient to relinquish control over her daily existence (Taylor, 1979:1). Hospitals are total institutions which manage all aspects of patient life. They are total in that they have complete control over the individual for a given period of time during which the individual is shut off from the outside world (Goffman, 1961:63). Though few people ever spend more than several days in a hospital over an entire lifetime, the impact of those few days is tremendous (Taylor, 1979:1). Indeed, hospitals are so uniformly regarded as unpleasant places to be that psychiatrists are inclined to study those who want to stay in the hospital rather than those who want to leave as quickly as possible (Roth, 1972:425).

Robert Wilson remarks:

> The patient comes unbidden to a large organization which awes him and irritates him, even as it also nurtures and cures. As he strips off his clothing, so he strips off, too, his favored costume of social roles, his favored style, his customary identity in the world. He becomes subject to a time schedule and a pattern of activity not of his own making (Wilson, 1963:223).

The patient's reaction to hospitalization has received little attention from social scientists, despite the centrality of the patient to the hospital's organizational goals and function. Perhaps, like the personnel within the hospital, the social scientist has come to view the patient as a product of the hospital, who although he is the central focus of the organization, is also a passive participant in its activities (Taylor, 1979:2). John McKinlay describes hospitals as:

> Large scale 'health factories' . . . controlled by physicians processing the objects of their labor (patients), with tools of their labor (biotechnology) in the means of their labor (physical plant) and receiving levels of remuneration for their labor (salary scales)" (McKinlay, 1977:473).

The patient is the body that is manipulated, diagnosed and treated, but the patient is denied an active role in her own care. She is expected to be cooperative, pleasant and quiet (Taylor, 1979: 3). "Her role calls for passivity and self-effacement" (Emerson, 1971:83). Erving Goffman (Goffman, 1961:75) has suggested that it would be "much easier for the (hospital) staff overall if the patient were not a person but rather a non-interacting object."

The physician is the primary agent who relates to the patient the critical components of the hospital patient role she is expected to assume (Taylor, 1979:3). Depersonalization of the patient is accomplished by the routinization of procedures, bureaucratic entanglement, non-person treatment, and limited interaction with the physician (Goffman, 1961:79). The physician's brief and fragmented interaction with the patient serves to depersonalize the patient, because it is typically what Goffman describes as:

> . . . the wonderful brand of non-person treatment . . . whereby the patient is greeted with what passes for civility, and said farewell to in the same fashion, with everything in between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind (Goffman, 1961:341-2).

Non-person treatment also results from a simple lack of the common courtesies generally extended to a person. Physicians often forget the most basic civilities in their interactions with patients. This type of behavior serves to indicate to the patient that she is not an equal, that she has been relegated to a position of subordinate.

Further indication of this is evident when the physician uses either highly technical or euphemistic terms in discussing her case with colleagues in front of her without the acknowledgement of her presence. These conversations often alarm or confuse the patient, an effect to which the physician may appear oblivious, which is yet another indication of her subordinate position. The use of nursery talk reinforces this, and gives the patient a sense of lost identity and a return to helpless infancy (Taylor, 1979:6). In this study, one physician greeted a 42-year-old female patient with "good morning, how's my girl today . . . scoot down here, and let me get a peek at your tummy."

The new reality of the hospital world is further complicated for the patient because she is uncertain with whom and how she is supposed to interact. This is compounded by her inability to know where she fits into the division of labor within the hospital setting (Denton, 1978: 133). Feeling familiar and secure in one's own position in the division of labor requires knowing what is required of one's self and of others. The patient may interact with 17 different hospital workers in a single day but has no way of knowing the tasks of these people (Denton, 1978:132).

The patient faces two problems in locating herself in the hospital division of labor. First is the difficulty in identifying the occupational roles of those with whom she interacts. The second is the difficulty in attaching correct expectations to the roles once they are known, for example, do you make your request known to the doctor or to the nurse, when you want a pain reliever? (Denton, 1978:133).

The hospital workers recognize each other by slight differences

in uniforms and other symbols like badges or pins, but the patient is not privy to these secrets. Human interaction is mediated by the use of such symbols. By interpreting their meanings, a person is able to ascertain the meanings of another's actions and thereby know what her actions should be (Blumer, 1979:79). The patient may be told all the symbols upon admission to the hospital but this is easily blurred. The patient therefore enters a situation in which initially the symbols of the division of labor are unknown and difficult to differentiate. In everyday life, the symbols were familiar and interaction with others was based on one's own secure place in the division of labor (Denton, 1978:133).

Patients may define what they believe to be the division of labor only to discover later that they are mistaken. The familiar labels that the patient had for the physician defined his functions for her. The patient may learn that the real functions of the physician differ from the common image she held. The patient may expect the physician to fulfill the image of the family doctor with time to chat, only to find the physician visit is brief, abrupt and generally does not fit the image expected (Denton, 1978:134).

Becoming a patient also places one in a new and different authority structure (Denton, 1978:136). As a non-patient, a person might have had a position as a father, mother, teacher or executive. Upon becoming a patient, a person is placed in a position of little or no authority. This lack of authority is expressed in the expectation that the patient will depend upon the physician to see to it that her needs are met (Denton, 1978:134).

Patients must respond to two sources of power and authority in

the hospital, that of the organization and that of the physician. As an organization, the hospital has an interest in maintaining control over the patient's activities and in minimizing any disruption of hospital routine (Denton, 1978:135). Even the lowest participants in the hospital organization, such as housekeepers and orderlies, represent the organization and have the authority to restrict the patient's activities. In the hospital being studied, one of the maids refused to let a patient return to her bed because the floor the maid had mopped was still wet, and she did not want the patient to walk across it. Even though the patient has the choice of leaving the hospital, this is not a free choice, in that it may result in negative consequences for her health. In the hospital being studied, if the patient should choose to leave, she would be requested to sign a legal document releasing the hospital of any responsibility for her health. This symbolic intimidation reminds patients that "the hospital has something that they need, and to receive it, they (must) become patients and relinquish the authority they had in their non-patient role" (Denton, 1978:135).

The patient is also made aware of the physician's personal authority, which is based on the knowledge that he has and the patient perceives as needing (Denton, 1978:135). The high status and prestige given to physicians in American society may tend to increase the physician's authority. Regardless of whether the social status of the patient as a non-patient was greater or lesser than that of the physician, in medical matters, the patient must defer to the greater knowledge of the physician.

Friedson argues that patients have some power over physicians

because they can withdraw as clients (Denton, 1978:135). But a patient's threat to find another physician is commonly met with the physician's statement that the patient is welcome to do so. In this context, the patient has not gained in power over the physician, she has only gained a different authority figure.

The patient in the hospital also finds herself in a social structure where her position and the expectations attached to it are uncertain (Denton, 1978:139). Individuals in everyday life usually work out differences between themselves and others through communication and interaction. Patients, however, now find themselves in a situation where the manner of communication and interaction with others is strange to them. A physician's "good morning" does not require the same response as a similar greeting in everyday life. The question, "did you pass your water?" has nothing to do with the everyday meaning of water. Everyday language is useless in the hospital situation and it is language that creates and gives meaning to reality for the individual. "An understanding of language is . . . essential for any understanding of reality . . ." (Berger & Luckmann, 1967: 37). Language "creates and disseminates the social knowledge of one's own situation and its limits of interaction with others" and establishes the standards and patterns of conduct (Berger & Luckmann, 1967:38).

One study that illustrates the importance of language is Emerson's (Emerson, 1971:81-2) study of patients undergoing gynecological examinations. She found that the special language used in physician/patient contacts contributes to the depersonalization and desexualization of the encounter. Using medical terminology and substituting diction-

ary terms for everyday words adds formality, protects the physician and gives him social distance. The doctor refers to "the vagina" not "your vagina," and frequently uses euphemisms such as "when did you first notice trouble down below?"

Another reason physicians give for using this type of language when relating to the patient is that the patient lacks the knowledge and the vocabulary to communicate with him in any other way. This may or may not be true, but the assumption clearly indicates that physicians perceive patients to be in a lower social class. It may also be that the patient, in awe of the physician's knowledge or status, may choose to use this type of language because she thinks it pleases him. American society has deified the physician and the patient is expected to show both gratitude and admiration for him because he is trying to help her get well. The patient feels not only obliged to cooperate, but obliged to seek approval from the physician, as well (Tagliacozzo, 1979:196).

In American society, the obligation to be a cooperative patient is learned early in life and is taken very seriously by most patients. A more aggressive interpretation of the patient role is not easily verbalized and is not often a realistic alternative for the patient. Self-assertion as a consumer is frowned upon by health professionals. It is also not very practical or necessarily in the best interest of the patient to be assertive (Tagliacozzo, 1979:196).

The patient sees few areas over which she has control because she is unable to evaluate the knowledge, skill and competence of physicians and she is not free to impose her judgment. She has so little control that she may fear such action will risk her chances of

getting good care. The patient may also feel that if she is cooperative, the physician and others will meet their obligations to satisfy her expectations. The restraint exercised by the patient is partly an expression of the fear that she may be deprived of important service should she deviate from acceptable behavior (Tagliacozzo, 1979:197).

A study by Judith Lorber (Lorber, 1979:215) demonstrated that doctors expected to carry out their work by well-established routines with a minimum amount of interruption from patients. Those patients who did not interrupt the smoothness of medical routines were likely to be considered good patients and those patients who refused to cooperate with medical routines and obstructed the work of the staff were considered problem patients or bad patients. The problem patients in the study were tranquilized, sometimes discharged early, and in one case referred to a psychiatrist. Consequences of not conforming to the sick role as expected by physicians can be medical neglect or a stigmatizing label, while conformity to the good patient norms assures the patient of good medical care.

Good patients don't waste the physician's time by asking a lot of questions. Limiting communication with the patient saves time and serves other functions for the physician as well. It keeps the interaction instrumental, reduces unpleasant emotional exchanges, and protects against the discovery of medical error. From the patient's perspective, however, limited communication reduces the effectiveness of the social skills that she would normally use to fit herself into a strange social structure (Denton, 1978:137). It limits her acquisition of knowledge as well and thus increases the physician's power advantage.

In summary, the social structure of the hospital prevents the patient from knowing where she fits into the new division of labor, places her at the bottom of the new authority structure and prohibits her from acquiring the necessary skills to function in the new social structure. In fact, the patient is incidental to this structure. She must fit into a bureaucratic organization that has been designed so that specific goals can be accomplished with maximum efficiency and minimal effort and little disruption. The hospital organization is one where duties are clearly defined and intermeshed into a very complex system of officially defined positions and roles, fixed boundaries, communication networks and hierarchical levels of authority (Downs, 1967:25).

The Role of the Physician

The physician enjoys the supreme position in the hospital organizational hierarchy. It is the physician who establishes and maintains the rules that regulate patient care in the hospital and it is only through the physician that the patient can access the health care system. Herbert Blumer (Blumer, 1969:58) suggests that all organizations "represent the application of somebody's definition of what the organization should be." It is the physician who defines the goals and objectives of the hospital and sets the standards for patient care. It is also the physician who defines illness. It is the medical orientation, therefore, that creates the social reality of a sick person (Bashshur, 1979).

The physician is granted the authority to define illness because

he possesses a "body of knowledge that defines and constructs the roles to be played in the context of the institution" of health care. According to symbolic interactionist theory, this body of knowledge produces a division of labor. Language then transmits the necessary knowledge to control conduct in the division of labor. A whole segment of the social world is created by this knowledge. This social world has the power to shape an individual and produce a specific type of person, namely the physician. To practice medicine and to be a physician implies existence in a social world defined and controlled by a body of knowledge (Berger & Luckmann, 1967:67).

Depending upon the complexity and the importance of this knowledge to a particular collectivity, the knowledge may have to be reaffirmed through symbolic objects and actions (Berger & Luckmann, 1967:71). The symbols of medical practitioners are highly visible and are evident in the doctor's office, the white coat, the presence of the nurse "chaperone," the framed medical degree, the stethoscope, etc. (Bashshur, 1979). These function to remind both the doctor and the patient of the roles they are expected to play.

> The institution with its assemblage of programmed actions is like the unwritten libretto of a drama. The realization of the drama depends upon the reiterated performance of its prescribed roles by living actors. The actors embody the roles and actualize the drama by representing it on the given stage (Berger & Luckmann, 1967:75).

Roles make it possible for institutions to exist. By virtue of the role he plays, an individual is inducted into specific areas of knowledge, not only in the narrower cognitive sense but also in the sense of the knowledge of norms, values, and even emotions (Berger & Luckmann, 1967:76). This knowledge may become so internalized that the individual considers the role "an inevitable fate for which (he)

may disclaim responsibility." "I have no choice in the matter, I have to act this way because of my position" (Berger & Luckmann, 1967:91). There is then a "total identificiation of the individual with his socially assigned role" and he is identified as nothing but that type" (Berger & Luckmann, 1967: 91). Significantly, the physician loses his civilian status upon entering medical school. Medical students begin calling one another "doctor" and they become "doctor" to everyone (including their wives) for life (Bashshur, 1979).

The character of occupational socialization depends upon "the status of the body of knowledge that is the foundation for the symbolic universe." The criteria to enter the socialization process "are established institutionally to enhance the prestige of the roles or to meet other ideological interests" (Berger & Luckmann, 1967:141). Typically, the socialization process requires that the individual commit himself fully to the reality that is being internalized. The socializing personnel take on the role of significant others and the individual being socialized becomes emotionally dependent upon them and establishes a strong identification with them (Berger & Luckmann, 1967: 157). The individual must commit himself in a comprehensive way to the new reality of his existence. This is especially needed in institutions where the individual is being socialized into an official reality-defining role, like that of a physician (Berger & Luckmann, 1967:145).

Physicians learn their roles through a complex socialization process that begins when they enter medical school. The rigors and expense of medical school, the admission requirements, the protege system and the collegial bonds of the medical profession all reflect the above theoretical framework for occupational socialization. Upon

completion of medical school, the symbolic universe of the physician includes elaborate rights, obligations and standard practices. Examples of these are evident in public deference, licensure and the ceremonious Hippocratic Oath. This symbolic universe also requires a role-specific vocabulary and routine interpretations and conduct within the institution. The physician is now socialized to play his role as definer of reality for the patient.

In any discussion of the role of the physician a significant amount of attention must be given to professionalism. The source, structure and characteristics of professionalism place professionals in a position of dominance. Professionalism is considered the ultimate in occupational status in American society and the physician is the prototype of professionalism (Bashshur, 1979).

According to Eliot Friedson (Friedson, 1970:158), a profession attains and maintains its position by virtue of the patronage and protection of some elite segment of society which has been persuaded that there is some special value to the professions' work. Its position is thus secured by the political and economic influence of the elite which sponsors it. This influence drives competing occupations out of the same area of work and discourages others by virtue of the competitive advantages conferred upon the chosen occupation. It requires still others to be subordinated to the position. The work of the chosen occupation is unlikely to have been singled out if it did not represent or express some of the important beliefs or values of that elite. But since chosen by the elite, it need not represent the values of the average citizen. The work of the profession is dynamic and it may eventually diverge from the views of the dominant elite,

but the dominant elite have to approve it in order for it to survive.

According to Friedson (Friedson, 1970:185), the formal criteria of a profession include determination of its own standards of education and training, legal recognition by some form of licensure which is granted by boards that are manned by members of the profession, control of the legislation concerning the profession and autonomy that permits the practitioner to be relatively free of lay evaluation and control. The profession's service orientation is accepted by the public, and the profession's leaders have persuaded society to grant and support its autonomy.

Autonomy is a critical factor in professionalism. It allows for self-regulation and it influences the outcome of the interaction between political and economic power and occupational representation. Friedson has shown how medicine as an organized profession controls the knowledge, skill and technology that compose the means of production, and how this control makes it possible for the medical profession to maintain its position of dominance in American society.

The Role of the Patient

The patient has had no preparatory socialization on how to be a patient (Denton, 1967:141). One learns the expectations and conduct as part of the admitting procedures into the hospital which serve to change a person into a patient. There is no time for the internalization of norms. The patient is unfamiliar with the division of labor, authority structure, and lifestyle of the hospital, so she has no standards for behavior, and therefore no typifications as a reference point from which to negotiate her reality.

According to symbolic-interactionist theory, when an individual "switches worlds," and her subjective reality is transformed or modified, a process of resocialization is required. This process resembles primary socialization because it has to change reality for the individual and consequently must replicate the strongly affective identification with, and emotional dependency upon the socializing personnel who were characteristic of childhood (Berger & Luckmann, 1967:157). This socialization process cannot begin until it first dismantles and disintegrates the previous reality. The socializing personnel must become the significant others who mediate the new reality to the individual. This requires a physical segregation of the individual from the "inhabitants of the other world," especially the "cohabitants" (Berger & Luckmann, 1967:158). This is especially necessary since creating a new reality involves a reorganization of the conversational apparatus and a change in signficant partners in conversation because it is in conversation with the new significant others that the patient's subjective reality is changed (Berger & Luckmann, 1967:159).

The old reality must be reinterpreted within the new reality. "This reinterpretation brings about a rupture in the subjective biography of the individual in terms of B.C. and A.D." (Berger & Luckmann, 1967: 159). The patient may now refer to "Before my heart attack, I smoked cigarettes," and "after my heart attack, I stopped smoking." Once the old reality is reinterpreted, it is possible to prescribe a new reality for the patient and the transformation may be considerable (Berger & Luckmann, 1967:161). In cases of short-term hospitalization, "the transformation may be fairly radical but temporary in duration," while "chronic patients may require full

resocialization" (Berger & Luckmann, 1967:163). Typically, then, the patient hospitalized for a short period of time will experience a new reality, one that is socially constructed for her through her interaction with the physician. If she regains her health, she will return to her old reality upon discharge from the hospital.

Clearly, this framework is a workable one within which to analyze the patient's hospital experience. The patient is subjected to the physical segregation of the hospital and its subsequent environmental shock. She encounters a depersonalization process which strips her identity and dismantles her previous reality. The physician acts as the primary socializer, agent of social control, and interpreter of past experience (symptoms, health status, etc.) for the patient. His power advantage enables him to place the patient in a position of dependency and subordination. Through social interaction, he has constructed a new reality for the patient.

The theoretical framework of symbolic-interactionism promises to be useful to a new understanding of the physician/patient encounter, and is appropriate for the study of the power process that constructs this power advantage for the physician and allows him to create this new reality for the patient.

Symbolic-Interactionism: A Discussion of a Micro-Theory

Symbolic-interactionism derives its root proposition from Marx--" that man's consciousness is determined by his social being," and that "human thought is founded in human activity (labor) and in the social relations brought about by this activity" (Berger & Luckmann, 1967: 6).

Herbert Blumer (Blumer, 1969:1) coined the term "symbolic interactionism" and his concept of this approach relies chiefly on the thought of George Herbert Mead. Mead's analysis of symbolic interactionism sees it as a presentation of gestures and a response to the meaning of those gestures. A gesture is defined as any aspect of an ongoing action that signifies the larger act of which it is a part. Gestures can be such things as requests, commands, orders, cues, declarations, etc. The person who responds organizes his response on the basis of what the gestures mean to him while the person who presents the gestures advances them as an indication of what he is planning to do and what he wants the respondent to do or understand (Blumer, 1969:9).

Blumer (Blumer, 1969:2) advances the idea that symbolic interactionism can be explained on the basis on three premises. The first is that human beings act toward things on the basis of the meanings they have for them. Blumer defines things as everything the human being comes in contact with in his world: physical objects, other people, institutions, activities of others and situations. Secondly, he suggests that the meanings of things arise out of the social interaction that one has with others. The third premise is that these meanings of things are interpreted by the individual while he is dealing with them.

Blumer (Blumer, 1969:5-8) emphasizes that meanings for things arise out of the process of interaction between people. Their actions operate to define the thing and these meanings are used as instruments for the guidance and formation of action. Seen in this way, symbolic interactionism views "social interaction as the process that

forms human conduct." Any given sphere of life under study must then be viewed as a moving process in which the participants are defining and interpreting each other's acts.

It is important to see how the process of designation and interpretation is sustaining, undercutting, redirecting and transforming the ways in which the participants are fitting together their lines of action (Blumer, 1969:53). Symbolic interaction is not preordained or static. It involves the continuous ongoing interpretation of the meaning of the actions or remarks of the other person and then fitting one's own acts to the ongoing acts of another (Blumer, 1969: 66).

Max Weber (Graber, 1975:68) supports this notion that social action is interpretive and oriented to the behavior of others. He suggests that it is not necessary to know the psychological motives of the actors in order to analyze social action. Interpretive sociology, he says, is not interested in motives, it is interested in the analysis of behavior. According to Weber, actors in a social situation use their behavior to reach a desired result. By observing the behavior, you can formulate certain conclusions about the purpose of the action, and action is always an understandable specific behavior toward objects.

Because of its theoretical focus on human interaction, symbolic interactionism is able to embrace all human relationships. The participants in each situation have the common task of constructing their acts by interpeting and defining the acts of each other (Blumer, 1969:67). Each participant occupies a different position, acts from that position and engages in a separate and distinct act. The par-

ticipants each attempt to fit their acts together however, by interpreting and defining the acts of others and using these acts as a guide for their own behavior (Blumer, 1969:70).

Blumer (Blumer, 1969:72-76) sees society as people meeting various situations that are thrust upon them by their conditions of life and attempting to work out joint actions in which they align their acts to one another. Each participant does so by interpreting the acts of others and in turn by making indications to others as to how they should act. The participants may fit their acts to one another in an orderly fashion on the basis of compromise, out of duress, to achieve respective goals or out of sheer necessity.

Through previous interaction people develop and acquire common understandings or definitions of how to act in certain situations. Since ready-made and commonly accepted definitions are at hand, little strain is placed upon people in guiding their actions in these kinds of situations. However, many other situations may not be defined. In this event, their lines of action may not fit together and interpretations must be developed and accommodation to one another needs to be worked out. According to Blumer (Blumer, 1969:86), in the case of such undefined situations, it is advantageous to trace and study the emerging process of definition that is brought into play. The physician/patient encounter is such a situation.

Blumer (Blumer, 1969:73) advocates that the recommended research be conducted in such a manner that the study of action be made from the position of the actor. Since action is forged by the actor out of what he perceives, interprets and judges, one must view the operating situation as the actor sees it, perceive objects as the

actor perceives them, ascertain their meaning in terms of the meaning they have for the actor, and follow the actor's line of conduct as the actor organizes it. The researcher must take the role of the actor and see his world from his standpoint. It is the intent of this study to accomplish precisely this. A micro-study of the physician/patient encounter promises to reveal the emerging process of definition that results from the behavior of the participants by viewing the operating situation and observing the formulation of conduct by the principals.

Blumer (Blumer, 1969:88) sees large organizations such as hospitals "as arrangements of people who are interlinked in their respective action." At any one point, participants (patients) may be confronted by the organized activities of these people into which they must fit their own acts. The social organization enters into the action to the extent to which it shapes situations in which people act, and to the extent to which it supplies fixed sets of symbols which people use in interpreting their situation.

This notion is supported by Erving Goffman (Goffman, 1959:241) who defines a social establishment as any place surrounded by fixed barriers in which a particular kind of activity regularly takes place. According to Goffman, a team of performers within the social establishment cooperate to present to an audience a given definition of the situation. Typically, but not always, agreement is stressed and opposition or conflict is underplayed. This attempt to achieve agreement is contradicted however by the fact that the performers carefully control communication with the audience when they are present and express a different attitude toward them when the audience is absent. Goffman believes this framework to be characteristic of

nearly all American social interaction. He suggests that this dramaturgical perspective is dependent upon techniques of impression management that are employed by the members of the social establishment. For example, if an individual is to direct others, he will often find it useful to keep strategic secrets from them, but it will be necessary regardless of his power position to convey effectively what he wants done. Power of any kind must be displayed and will have different effects depending upon how it is dramatized.

Goffman (Goffman, 1959:248-9) advances the idea that impressions are the means by which recipients guide their responses without having to wait until the full consequences of the informant's actions are felt. Since the reality for the individual is not always perceptible, appearances must be relied upon. Ironically, the more the individual is concerned about the imperceptible reality, the more he must concentrate on appearances. Typically, physicians and hospital staff are experts at withholding information from patients, information that is vigorously sought by patients because of the very personal nature of illness. Goffman describes communication techniques such as innuendo, strategic ambiguity, and crucial omission that allow the experts to profit from lies without technically telling any (Goffman, 1959:62). Doctors rationalize these "white lies" as protecting the patient, sparing their emotions, or as acceptable because the patient wouldn't understand, when in fact, the withholding of information is a form of impression management necessary to control the social encounter and sustain an official definition of the situation. Such a technique enhances the medical mystique and contributes to professional dominance in the physician/patient encounter.

Goffman (Goffman, 1959:23) suggests that stagecraft is crucial to social interaction if one is to influence the observers. He indicates that the setting, funiture, decor and physical layout provide "the scenery and the stage props for the spate of human action." He notes that recent developments in the medical profession have made it increasingly important for a doctor to have access to the elaborate scientific stage provided by large hospitals.

There is substantial evidence to indicate that the increased technology of modern medicine has increased the physician's dependence upon the hospital to provide the necessary equipment for the practice of medicine. Additionally, technology has reified the mechanical model for medicine and subsequently widened the gap between what patients seek and physicians provide (Eisenberg, 1977:9). Technology has also expanded the information base for medicine, and physicians control this information. From this perspective, technology has substantively contributed to the power that physicians have over the outcome of the physician/ patient encounter, power as a result of the body of knowledge that physicians have and patients need.

All knowledge is socially distributed and the mechanism of this distribution is dependent upon the structure of the social environment in which the social interaction and the exchange of knowledge takes place (Berger & Luckmann, 1967:16). A micro-analysis of the physician-patient encounter within the social environment of the hospital should provide valuable insights into this exchange of knowledge.

Peter Berger and Thomas Luckmann's (Berger & Luckmann, 1967:19) treatise in the sociology of knowledge claims that reality,

what is real and meaningful to a person, is constructed through the social interaction the individual has with others. Individuals interact with one another as a result of the knowledge they have of the situation. Negotiation of the situation is possible only when both participants have the knowledge that is necessary to accurately interpret the situation.

According to Berger and Luckmann (Berger & Luckmann, 1967: 20-24), everyday life presents itself as a reality that is interpreted by men and is subjectively meaningful to them as a coherent world. It is a world that guides their conduct and originates their thoughts and actions. This world of everyday life is taken for granted as reality by ordinary members of society. It is an ordered reality that is filled with meaningful objects and a language that gives it sense and meaning. Everyday life is an intersubjective world of common sense that one shares with others. It is routinized and as long as routines continue without interruption, there is no problem, but when problems occur, the reality of everyday life seeks to integrate the problematic with the unproblematic.

Problems may transcend the boundaries of the reality of everyday life and create an altogether different reality for the individual, one that is marked by circumscribed meanings and modes of experience.

> The transition between realities is marked by the rising and falling of the curtain. As the curtain rises, the spectator is transported to another world with its own meanings and an order that may or may not have much to do with the order of everyday life (Berger & Luckmann, 1967:25).

The individual's attention is turned away from everyday life and

under these new circumstances, everyday language doesn't work to interpret the new experiences, and reality is distorted for the individual (Berger & Luckmann, 1967:26).

When persons become ill and require hospitalization they experience just this type of reality distortion. The reality of their everyday life is displaced by a new reality that is socially constructed through symbolic interaction with the physician. He creates a new reality for the patient, using the hospital as the social organization and the hospital staff as agents of social control. Even though symbolic interactionism implies a negotiation of reality, I challenge the idea that this new reality is negotiated between the patient and the physician. I submit that the disproportionate power advantage that the physician holds over the patient limits any legitimate negotiation of this new reality.

Symbolic interactionism theorizes that the social interaction of everyday life creates one's self-image and contains the reciprocal typifications that define how one deals with others. These shared typifications are developed and made possible by shared language, significations and symbols, all of which contribute to produce shared knowledge (Berger & Luckmann, 1967:33).

It is my contention that the physician/patient encounter is <u>not</u> based on reciprocal typifications because of the lack of shared knowledge between the participants. Furthermore, shared knowledge is absent from the physician/patient relationship because the physician chooses it to be. Language, signification, and symbols in health care are designed to obscure rather than to illuminate, and therefore they keep the patient in a low state of knowledge. This keeps the physi-

cian in a highly disproportionate position of power and limits the patient's ability to negotiate the reality that emerges from the physician/patient encounter.

This study using the symbolic-interactionist framework promises to look beyond the power relationship to the very process of behavior that awards that power to the physician. According to Blumer, (Blumer, 1969:8) social interaction is the process that forms human conduct.

Symbolic interactionism, as an interpretive or cognitive approach, subscribes to the theory that individuals define each situation and then subsequently construct their action. There are different strands of micro-theory, but they all bear upon this study because they all deny the traditional sociological approach that individuals learn roles and act accordingly in a given situation. It has been suggested that "traditional sociology reduces individuals to hollow actors merely doing social actions" (Beng-Huat Chua, 1974: 243).

Symbolic-interactionism emphasizes the developmental properties of interaction while the usual structural approach in sociology tends to neglect microscopic analysis of interaction and its developmental character (Glazer & Strauss, 1964:678). By uncovering the developmental properties of social interaction, it makes possible "the undoing of the occasioned reality." Symbolic interactionism as a framework can be "a powerful tool for the demystification and de-objectification of the products of human activity which are either reinforced or taken implicitly as the necessary boundaries of behavior" (Beng-Huat Chua, 1974:253).

Berger and Luckmann (Berger & Luckmann, 1967:19) propose

that "reality is socially constructed" and that "human beings create or construct their own social reality in their interaction with others." They maintain that:

> The theoretical formulations of reality, whether they be scientific or philosophical, or even mythological do not exhaust what is 'real' for the members of a society . . . the sociology of knowledge must first concern itself with what people 'know' as 'reality' in their everyday lives. In others words, common sense 'knowledge' rather than 'ideas' must be the central focus . . . It is precisely this 'knowledge' that constitutes the fabric of meanings without which no society could exist (Berger & Luckmann, 1967:15).

Those who support symbolic-interactionist theory rely heavily upon the idea that human behavior is a result of the interpretation of the everyday world of objects. Shibutani argues that the only way to understand human behavior and its organization into diverse types of social patterns is "to comprehend the world of objects created by the interacting parties" (Shibutani, 1961:96). Human behavior is, therefore, organized around objects with the symbolic and definitional capacities of humans determining their meaning and human action (Turner, 1974:283). D. Zimmerman and D. L. Wieder (Morris, 1975: 170) advance the notion that "the social world does not exist independently of the social meanings that members use to account it and hence constitute it; social structure has no identity independent of member's everyday sense of it."

There has been considerable debate over the usefulness of symbolic interaction theory and some classical sociologists have criticized its practicioners for not "spell(ing) out the social implications of their approach" or for simply "confine(ing) themselves to analyzing the rules that seem to govern everyday behavior." Others see symbolic interactionism as a "new" kind of functionalism where "human

behavior is seen to be the lack of socially shared roles or norms--a function of meaninglessness" (Morris, 1975:172).

Jonathan H. Turner (Turner, 1974:283) outlines the points of convergence between functionalism and interactionism. He suggests that both perspectives are quite similar and that the divergence between them represents more of a strategic difference over how sociological research should be conducted than a disagreement over the nature of the social world.

A major criticism of symbolic-interactionism is that it is founded upon the idea of reality negotiation and its theorists refuse to admit any inflexibility in the social world. Social reality develops freely as a series of bargains negotiated and struck by the members. Its critics say that this approach "ignores the fact that some people's definitions of reality carry more weight than others and may even impose upon others . . . it assumes that every man is in a position equal to everyone else" (Morris, 1975: 173). Randall Collins and Michael Makowsky (Morris, 1975:172) remind us that "while negotiation of reality may be possible, we are all aware that those with economic and military power are more able to make their definitions of reality stick." Other critics have noted that there has been relatively no concern with the nature of power or its distribution in society with, they concede, the possible exception of Goffman's work in which he deals with the power of the institution to determine the reality that will be accepted (Morris, 1975:173).

George Gonos (Gonos, 1977:855) argues that Goffman, presumably a symbolic-interactionist and a major spokesperson for this school, implies a structuralist perspective in his theoretical work.

He argues that while interactionists attempt to deal with the unfolding of actual everyday events, it is Goffman's intent to 'see behind' this constant activity to the "structures" that invisibly govern it (Gonos, 1977:857).

According to Gonos (Gonos, 1977:858), the first issue with Goffman is not interaction, but frame. Gonos accuses those who have studied the process of "defining the situation" of ignoring the micro-structures within which this informal activity of defining takes place. He suggests that Goffman's study of everyday life has made these "frames" its focus. "Frame analysis" asks about "the central working principles that animate any particular mode of activity." It is "an attempt to become cognizant of the rules for cognition and communication that are bound up with the production of any world."

Gonos (Gonos, 1977:862-67) argues that the focus and strength of interactionist theory is that each situation is not constituted of imposed formal rules but informal ones that are ongoingly "negotiated." He maintains that Goffman sees the situated encounter as being "tied to the larger social structure" and conduct guided by the "individual's place with respect to the social relations of production of a ritual world." Interactionists emphasize the world-building capacities of people in everyday situations and look to them as the source of social change while Goffman thinks of indivudals as "supports" for the existence of social structures and as "resources" called upon to bring activity to life. Goffman uses the sociology of everday life to identify the reality of frame and it remains for sociologists to analyze the place of frames of everyday life within political and economic systems.

Goffman's approach is especially relevant to the study of the

physician/patient encounter within the American hospital setting. The hospital is a social organization with its own system of roles, statuses and norms that define the various functions and skills of its incumbents. The "medical model" of patient care has dominated the social structure of the hospital with the emphasis on technical and physical care permeated by an authoritarian caste-like social structure of staff dominance and patient subservience (Georgopoulos, 1979:295). This social structure significantly impacts upon the physician/patient encounter and is therefore germane to any discussion of the relationship.

J. H. Goldthorpe supports the relevance of structure as well.

> The study of actors in interaction in a situation is of value but to disregard . . . such matters as the econological, demographic, technical, economic and political conditions constraints and facilities of interaction is to have less than a complete understanding (Morris, 1975: 170).

Several scholars have found the symbolic-interactionist framework useful in the study of human relationships. For example, in the arena of marriage, Peter Berger and Hansfried Kellner (Berger & Kellner, 1977:262) suggested that "men" construct a social reality with which they can cope and protect themselves from a sometimes hostile outside environment. This analysis ignores women who apparently have no comparable context into which they can escape from their everyday frustrations, but it is useful because it demonstrates the limitations of the process of negotiation in the social construction of reality. Nona Glazer's (Glazer, 1977:259) critique of this analysis, however, suggests that the relation between culture as a determinant of social behavior and social interaction as a determinant of social reality become blurred. She claims that it is not the idiosyncratic

development of social reality that gives the man the chance to bolster his sagging self-esteem and low morale but rather the cultural norms that prescribe the role of home manager for women.

Sherman Eisenthal and Aaron Lazare (Eisenthal & Lazare, 1967: 739-748) developed a "negotiated approach" to patienthood out of the experience of operating a walk-in clinic at a general hospital. They proposed that the same treatment be afforded to how the patient defines her problem and solution as is afforded to the physician's definition of the patient's reality. They gained the patient's perception of her reality in the conduct of the initial interview and they found that 31% of the patients did not verbalize a specific request to a direct and non-threatening standard elicitation probe. They evaluated this as a very salient finding in view of the assumption of the negotiated approach that most if not all voluntary patients have requests. Their data showed that patients are more apt to make specific requests for treatment on written questionnaires rather than to verbalize these requests. They suggest that personal and normative constraints play a significant role in such behavior and indicate that future research is needed to identify the nature of these constraints in the face-to-face interaction between patient and clinician. It is their thesis that negotiations over treatment conducted without attention to the patient's perceptions and requests are handicapped by a lack of essential information and are thus less effective.

Rita Seiden Miller (Miller, 1978:181-204) has contributed to the evidence of the social construction of reality with her study of the acquisition of the pregnancy identity. She concludes that all identities are acquired through the processes of social construction of

realities which may be independent of objective realities. She focuses on how pregnant American women bring together social and physiological pregnancy to acquire a pregnancy identity. Her main thesis is that physiological events have no meaning until actors choose to ascribe meaning to them. Her data supports the view that physical signs are transformed into evidence of social pregnancy through a typically, speedy, informal, "invisible" process of social construction of meaning. The pregnant women tentatively recognized their new identities but awaited further confirmation by a physician before they acknowledged their identities as fully "real." Her analysis relies heavily upon labeling theory.

Labeling ascribes an identity to an individual and defines to some extent how she is expected to behave and how others should behave toward her. Labeling requires a minimal degree of concensus between the individual concerned and the significant others who act as status definers. The physician is the ultimate status definer in labeling illness (Mechanic, 1978:249) and significant to our discussion is the fact that physicians have labeled pregnancy as an illness.

A. Thio suggests that:

> An undercurrent of class bias flows beneath labeling theory. It provides tacit support of the power elite. . . . labeling theory focuses on the deviance of the powerless class, neglecting the deviance of the powerful . . . it supports the power elite in their concentration on the individual deviant or his immediate millieu and neglects an analysis of the established power structure . . . (Morris, 1975:175).

Labeling theory equates deviance with powerlessness and makes deviance a consequence of labeling by superordinates. Labeling theorists rely heavily upon symbolic interaction because the focus is on reactions to behavior and the manner in which it becomes defined as

deviant. Observation is crucial to labeling theory. It is easier to observe the actions of the powerless than of the powerful, so labeling theory reinforces class bias (Morris, 1975:175). The Parsonian view of illness defines it as a deviant response (Parsons, 1975:29). The patient labelled as deviant by the physician becomes a victim of class bias. This study is especially signficant in terms of labeling theory because it provides an opportunity to observe the behavior of the powerful who do the labelling and determine how that behavior reinforces labeling theory.

Carl Hosticka (Hosticka, 1979:609) reminds us that power is exercised through the official definition of reality. He analyzed lawyer-client negotiations of reality with a focus on the power relationships that develop during this negotiation. His emphasis was on who controlled the key aspects of the negotiation and how that control was exercised. He observed fifty client/lawyer interactions and concluded that lawyers dominate the interview process, control the interaction and shape the reality that emerges. There was some evidence to suggest that this behavior yielded inappropriate descriptions of client's problems. This in turn suggested that services specifically established to respond to consumer needs do not necessarily consider the consumer wishes. He argues along with Hughes that professionals "presume to tell society what is good and right for the individual and for society at large in some aspects of life. Indeed (professionals) set the very terms in which people may think about some aspects of life."

Eliot Freidson (Freidson, 1970:91) has contributed insightful, comprehensive knowledge regarding the concept of professional domi-

nance and how it relates to the physician/patient encounter. He analyzes the relationship as one that is potentially and inherently conflictual because of the differing perspectives that each participant brings to the encounter. Freidson's analysis concentrates on professionalism, however, and does not evaluate or analyze the situational aspects of the encounter. While professional dominance will be given substantial consideration in this study, the emphasis will be on the behavior of the participants in the concrete situational interaction with the anticipation that the behavior will further support the views of both Hosticka and Freidson.

P.M. Strong and A. G. Davis (Strong & Davis, 1977:779) accuse symbolic interactionism of largely ignoring the significance of role in the study of encounters. They are additionally impressed with the importance of the physician/patient interaction in the history of role analysis. They commend Talcott Parsons for his immense contribution to the analysis of this encounter and for bringing medicine into the mainstream of sociology by stimulating additional inquiry. They observe that now, for good reason, his work is largely ignored. They criticize him "for having failed to grasp the complexities of social interaction, for ignoring the fundamental conflict of interest between doctor and patient and their very differing resources and for being blind to the great varieties of form found both in medical practice and in illness behavior."

Talcott Parsons (Parsons, 1979:120) first saw the physician/patient relationship as being harmonious with both participants having similar goals and expectations. He later described the relationship as an "asymmetrical structure of the role relationship" with the physician

in a position of authority, power and prestige. Parsons suggested that the physician needed an asymmetrical power advantage over the patient in order to socialize the patient into adherence to the physician's regime. He advanced the idea that the power advantage is both necessary and welcome to the patient. It is the intent of this study to challenge that assumption.

Strong and Davis (Strong & Davis, 1977:775-781) point out that "the serious problems of interpretation, negotiation and alignment of action were simply irrelevant for Parsons." They also point out, however, that the interactionist's framework must include the role format that Parsons introduced in order to provide a sense of form that accounts for the overwhelming similiarity and continuity of experience that is present in everyday life.

Barney Glazer and Anselm Strauss (Glazer & Strauss, 1964:672) provided a paradigm for the study of awareness contexts and social interaction. Their study emphasized developmental interaction and suggested that an awareness context surrounds and affects the interaction. They studied dying patients in a general hospital and concluded that "the hospital is magnificently organized both by accident and design for hiding the medical truth from patients and the staff is trained or accustomed to act collusively around patients so as not to disclose medical secrets." They advanced the idea that physicians are supported in their withholding of information by professional rationales. Even family members or other patients will support the physician in withholding information because they feel he knows what's best for the patient.

These scholars identified certain interaction tactics employed by

the staff to prevent the patient's knowledge of the "real." The staff guard against the patient's overhearing any conversation about his condition, engage in careful management of expressions, and reduce the number of potentially disclosing cues by reducing time spent with the patient or by restricting their conversations with her. Day and night staff may give her contradictory information and the frequent practice of rotating personnel through the hospital services makes certain that the patient is constantly exposed to staff who are unfamiliar with her. The patient may become more knowledgeable about what is going on about her after some days in the hospital or after repeated hospitalizations. She may come to learn that the hospital is organized not to give her all the information that she needs about her condition but rather to withhold most information. When this occurs, the patient begins to distrust the accuracy of any information she may be given (Glazer & Strauss, 1964:672).

Glazer and Strauss (Glazer & Strauss, 1964:678) raise questions about interaction and structure that suggest that the interactionist analysis must include the structural conditions under which the interaction occurs. They indicate that the institutional context will facilitate or impede the acquisition of knowledge that is necessary to negotiate one's reality. They advance the idea however that the usual structural approach in sociology tends to neglect the microscopic analysis of interactional behavior and its developmental character. This study will address their concern by analyzing the behavior of the participants in the physician/patient encounter within the context of the social structure of the modern American hospital.

Perhaps the most significant contributions to the literature on

the physician/patient encounter as symbolic interaction are the works of David Hayes-Bautista (Hayes-Bautista, 1976:156-162). His study of urban Chicano patients sought to conceptualize the everyday rules by which a patient makes choices about which practitioner should be consulted for which illness. He began his study with the premise that a lay person must often choose a practitioner from competing specialists without the specialized knowledge needed to categorize them. Using the symbolic-interactionist framework, he observed patient interactions with physicians and concluded that the patients develop their own everyday knowledge during the course of these encounters and this knowledge formulates recipes or rules for the construction of their social world.

An additional contribution by Hayes-Bautista (Hayes-Bautista, 1976: 233-238) was his illuminating study of patient non-compliance as a means of asserting control in a patient/practitioner relationship. This study was grounded in the experience of 200 San Francisco Bay area Chicano patients. Again, the objective of this study was to conceptualize and theoretically order the everyday definitions and rules by which these patients assembled their world of health care action. He used recounted incidents of doctor/patient interaction as perceived by patients and obtained by interviews.

Hayes-Bautista claims the issue of power and control exercised by the patient has not been previously examined, that most of the work on the physician/patient relationship assumes professional dominance. He indicates that in spite of this socially defined power advantage, patients do often attempt to exert some measure of control. Previous studies have provided evidence that patients use

lay-referral systems, attempt to control uncertainty and gain awareness and in extreme cases may terminate the relationship with the physician in an attempt to gain control. The perspective of Hayes-Bautista's study was that the search for and receipt of medical care is a social activity subject to the pressures and constraints of any social interaction. His study of patient non-compliance clearly indicates the extremes to which patients must resort in order to exert some control over their own health. Typically, non-compliance is not in the best medical interests of the patient.

W. Timothy Anderson and David Helm (Anderson & Helm, 1979: 259) analyzed the physician/patient relationship as a process of reality negotiation between two or more participants with competing conceptualizations. They advanced the idea that perceived reality is subjective in nature and is influenced by prevailing ideologies, environment, social contacts, and numerous other factors. During an encounter differing perceptions are held by the actors involved, and the process of reaching some accord about the true nature of reality is a process of reality negotiation which rarely starts from a position of parity. Some individuals have or obtain a mandate to impose their definitions.

Anderson and Helm (Anderson & Helm, 1979:262) point out that physicians define health and illness and that these categories constitute a social reality distinct from any physical reality. They describe the physician/patient encounter as being complex, inherently conflictual and socially constituted with the physician maintaining a position of dominance. They analyze this dominance in terms of the components of the encounter. They argue that the patient comes to the physician, to his space, and on his terms. The physician is more

familiar with the setting, more comfortable, and less mystified than the patient. The patient must be available at the physician's convenience, is often kept waiting, and has little control over when the encounter is terminated. The patient is often disrobed while the physician is dressed. The physician most often is in a physically elevated position relative to the patient's position. The patient is typically alone while the physician generally has a nurse in attendance. The patient must give accounts to the physician which the physician then interprets for the patient. The patient is subject to physician evaluation, but the physician is not usually subject to client evaluation.

The interests, rules and concerns of the organization often set the tone for the physician/patient relationship in favor of the physician. In the case of the hospital, when the goals of the hospital and the patient do not coincide, it is possible that the physician will act in favor of the hospital, especially if he is a salaried physician. However, whether he favors the hospital or not, the perception of the physician's allegiance to the hospital by both of the participants, can increase the physician's advantage (Anderson & Helm, 1979: 267).

Anderson and Helm (Anderson & Helm, 1979:269) conclude that "the social construction of reality in the patient/physician encounter is structured in an asymmetrical direction favoring the physician's reality." They suggest that the encounter is a process of reality negotiation, and the patient has the ability to negotiate this reality with the physician. The patient can ignore the physician's orders, fail to see the physician, directly challenge the doctor's reality, and

in general be "irresponsible" in an effort to dominate the physician's reality. The patient can also try to change physicians or seek additional opinions.

I submit that these are not valid options for the patient as they all imply negative consequences for her health. Furthermore, the patient lacks the knowledge to evaluate the authenticity of the reality that the physician has created for her.

It is my contention that the physician creates and maintains a new reality for the patient, and that this reality is not negotiable because the socially constituted influences of place, structure, status, class, race, sex and language give the physician a disproportionate power advantage (Anderson & Helm, 1979:259).

Sex & Class Variables

It is anticipated that sex will prove to be a significant variable with considerable impact upon the power relationship between physicians and their patients. "Sexism in medicine . . . (is) deeply embedded in the individual subconscious as well as in the American culture" (Schiefelbein, 1980:12). "Women are the consumers of most health care services" and this "care is rendered almost exclusively by men--90% of the nation's physicians are male" (Schiefelbein, 1980:12).

> These male physicians have been accused of fostering dependence among women; i.e. encouraging their overuse of services, labeling them as neurotic, performing excessive surgical procedures on their reproductive organs, over-prescribing tranquilizers and numerous other medical 'crimes' against women (Lewis, 1977:863).

Diana Scully (Scully, 1980:42) in her recent book, Men Who

Control Women's Health, documents evidence that indicates that biases in the male-dominated profession do affect medical treatment and patient care. Scully documents the history of gynecology which began in the 19th century when slave women provided a readily available source for surgical experimentation without the use of anesthesia which had not yet become an acceptable medical routine. She documents her study of gynecological physicians in training today whose educational needs take priority over patient care and require that women must often sacrifice parts of their bodies. She calls attention to the fact that the hysterectomy is the most commonly performed major operation for women in the United States today, and that it is estimated that if the present rates continue, 50 per cent of all women in the United States will have a hysterectomy by the age of 65 (Scully, 1980:93).

In Scully's (Scully, 1980:92) study of obstetrician-gynecologists, she found that these doctors verbally expressed a strong desire to control their patients, believed women to be more submissive to authority than men, and admitted that they were able to experience a sense of power and control over their female clients (Scully, 1980:92). Scully provides the documented evidence that this power advantage is directly responsible for the unnecessary surgery on women today. She reports the techniques and approaches that are employed by physicians to gain consent for surgery from passive, dependent female patients. Joan Emerson (Emerson, 1971:83) in her study of gynecological patients stated that "her (the patient's) role calls for passivity and self-effacement." Scully is more succinct in her description. "It is difficult for anyone 'stripped and draped' to assert her rights" (Scully, 1980: 254).

The American health care system has consistently ignored the rights of women and is still doing so today. Barbara Seaman, with her physician-husband Gideon Seaman, has published a report (Scully, 1980:18) that documents that DES, now indisputably known to be a human carcinogen, is still being prescribed for women. Ellen Frankfort (Scully, 1980:19), in her book - Vaginal Politics, has described the American health care system as one that "treats women like children and denies them the opportunity to acquire the information necessary to make informed decisions." Gena Corea's (Scully, 1980: 20) recent The Hidden Malpractice describes how men came to dominate medicine and demonstrates the effect of that domination on the diagnoses of women's problems.

Phyllis Chesler's ambitious study entitled Patient and Patriarch: Women in the Psychotherapeutic Relationship (Chesler, 1971:362-92), vividly describes psychotherapy and marriage as the only two socially approved institutions for women.

> Both isolate women from each other; both emphasize individual rather than collective solutions to women's unhappiness; both are based on a women's helplessness and dependence on a stronger male authority figure; both may be viewed as reenactments of a little girl's relation to her father in a patriarchal society; both control and oppress women similarly--yet at the same time are the two safest havens for women in a society that offers them no others (Chesler, 1971:373).

Chesler further suggests that female patients are preferred over male patients because the physician enjoys the "experience of controlling and feeling superior to a female upon whom he can project many of his own forbidden longings for dependency and emotionality and from whom, as a superior expert, as a doctor, he is protected as he cannot be from his mother, wife, or girl friend."

Barbara Ehrenreich and Deidre English (Lorber, 1975:95) argue that the sexism of the health system is not incidental, not just the reflection of the sexism of society in general or the sexism of individual doctors. It is historically older than medical science itself; it is deep-rooted institutional sexism. This kind of sexism is reflected in the fact that "doctors ideologically (have) defined pregnancy and menopause as diseases, menstruation as a chronic disorder, and childbirth as a surgical event." This ideology helped licensed doctors to systematically exclude midwives from the practice of caring for pregnant women. It also was used by male physicians as a weapon in the battle between upper-class males and militant upper-class females. It was easy to argue that pathological female functions like menstruation and its accompanying nervousness made it dangerous for women to be emancipated socially, politically, or educationally. This same argument, supported by scientifically labelled premenstrual tension, is used today in the debate over the advisability of women in high public office.

Ehrenreich and English have researched and analyzed medical beliefs and practices related to women from 1865 to 1920. They found that female invalidism was encouraged in upper-class women because it gave doctors rich, passive, adoring patients to treat for long periods of time. Working-class women on the other hand were seen to be strong enough for back-breaking labor, even through pregnancy, but were labeled by the medical profession as carriers of disease. Through such practices, the male-dominated medical profession has been able to socially control women.

Judith Lorber (Lorber, 1975:98) suggests that "American women

as a class are particularly vulnerable to (this type of) social control" because the male-dominated medical profession controls the resources that women need as a result of their reproductive function. According to Lorber, the American medical profession "defines all adult women as sick on the basis of their reproductive functions" and this in turn means that such functions can "only be managed with professional expertise." In her article, "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients," Lorber (Lorber, 1975:98) calls for much more research on how doctors stereotype and respond differently to women and other members of different social groups.

Diana Scully's (Scully, 1980:237-239) study reinforces this idea of a dual health system based upon social class. She found it "painfully clear that for the poor, the cure can be worse than the disease," and in spite of this, "poor patients are expected to be grateful for what they receive." The resident physicians in the hospitals she studied admitted that they "disliked institutional patients," had difficulty communicating with the uneducated, and gave them substandard care. The closer the patient resembled the physician in background including ethnicity, marital status, education, income, age and religion, the better medical care she received. Large class and sex differences meant that patients "were treated like animals, not persons" (Scully, 1980:132), and patients who fell into this category frequently served as material to meet the needs of medical training and research. Typically, this kind of care is delivered in an atmosphere that is indifferent at best and often characterized by hostility and total disregard of the patient's human rights or dignity.

Evidence has accumulated to demonstrate that the lower-class patients have more surgical procedures performed, more teeth pulled, more injections rather than oral medications, and more hospitalizations. These differences in medical treatment are usually explained by physicians on the basis that lower-class patients are unable to manage the more conservative treatment regimens (Bashshur, 1979). The vast differences in status and power that are produced by physician expertise and patient dependence contribute to dehumanized care. When the patient's sex, class, or race increases this difference, the inequality is intensified (Scully, 1980:250) and the care deteriorates even more.

CHAPTER IV: FINDINGS OF RESEARCH

Demographic Variables

The demographic variables of age, class, race and gender had significant impact on the physician/patient encounters observed in this study. Those patients who were young, black, female or lower class were treated differently by the physician than the middle-aged, white, middle-class males. Patients with these variables also responded differently to the physician. The fact that their behavior appeared to be constructed as a response to the behavior of the physician, supports symbolic-interactionist theory.

The physicians in this study were observed to spend less time, give less information and reassurance and have less direct contact with those patients who were young, black, female or lower class. They also issued more direct commands, exhibited more paternalism, fostered more dependency and demonstrated more breach of courtesies with these patients. It was noted that these patients were less assertive, less informed, more dependent and more apprehensive about their surgical procedures. They reflected a passive acceptance of authority and often verbally expressed gratitude to the physician for what little attention they received, thereby exhibiting the deference that physicians expect, according to Scully (Scully, 1980:92).

Of all of the variables, gender appeared to have the most impact upon the encounter. Black, uneducated, male patients were given more detailed explanation and shown more courtesies than the white, college-educated females in this study. Being young, uneducated and

female appeared to be the worst possible combination of demographic variables for one to have. C.B. was an 18-year-old, pregnant, high school drop-out.

> The doctor walked into her room without knocking. He greeted the patient by saying, 'Connie, how are you doing?' He stood at the foot of the bed and without waiting for a reply to his question, he began talking immediately as he looked at the chart.
>
> The patient in response to his question answered quietly, 'I'm scared.' The doctor ignored this, looked up from the chart into the patient's face, moved toward her, touched her face and said, 'You have bad teeth.' The patient responded, 'Yes, I'm going to get them all pulled.'
>
> The doctor proceeded to step back and from foot of the bed explained to patient that a tube would have to be put down her throat and in the process some of her 'bad teeth' may be 'pushed out' and he couldn't be responsible for that. 'Will it hurt,' the patient asked. 'Do I have to have it put down?' The doctor without looking up from the chart said, 'yes.'
>
> The patient asked why she had to have it down if she didn't want it. The doctor's response without looking up from the chart was 'because we have to watch you breathe.'
>
> The patient asked if she would be out when they put the tube down, and the doctor answered, 'yes' without looking up from the chart.
>
> When he did look up, he said to her looking directly into her face, 'we can't guarantee that you'll still have your teeth, now do you understand that?' She shook her head, no.' He stepped forward and touched her arm then stepped back and pointed his finger at her like lecturing and said, 'I'm not saying definitely, but we just can't guarantee that teeth as bad as yours won't come out because of the intubation.'
>
> He told her that her 'cholecystectomy' was scheduled for 8 a.m. She said 'what's that? I thought I was having gallstones taken out.' The patient looked very tense at this point and the doctor continued to write on the chart.
>
> Although I had only been observing, I interceded at this point and told her a cholecystectomy meant having your gall bladder taken out.
>
> The doctor moved toward the patient and picked up her hand and took her pulse. He put his stethoscope on

and lifted her hospital gown and listened to her chest. All of these things were done without any verbal explanation.

He said, 'cough for me' and 'take a deep breath.' The patient coughed - all the time watching the doctor's face. He asked her if she had 'bronchitis' - she said 'no.' He asked her if she'd had a chest x-ray and began looking at her chart. She said, 'no, they won't do one because I'm pregnant.' He looked up and said 'you're pregnant?' and immediately began paging through the chart. He looked up and pointed his full hand at her and said 'this is a problem.' She asked why and he very abruptly said 'because of the anesthesia.' She asked if this would hurt the baby and without looking up he answered 'yes, we cannot guarantee that it won't.'

She became visibly upset and said, 'but the baby will be okay?' In very short, choppy sentences, he replied, 'I don't know. We do what's best. There's no other way. The surgery's got to be done.' The patient looked frightened. 'The doctor who's going to do the surgery - I don't know his name - told me it wouldn't hurt the baby.' 'How come he didn't tell me?'

The doctor said, 'Everything will be all right, we'll do what's best for you.' He moved closer to the patient's bed, 'You're too young - you don't have any choice - sometimes we worry too much.'

She asked, 'Will you put me to sleep?' He nodded, 'yes.'

He looked up and smiled at her for the first time. 'I've spent 1/2 hour explaining this to you.' 'All right?' 'Okay?' He asked repeatedly. She finally nodded.

He stood with his foot on the bed for a minute, then turned and walked out. She looked at me and started to cry. 'He thinks I'm too young' - 'He's crazy - I'm not too young, I just don't understand.'

Although her physician encounter was extreme and certainly reflected the most traumatic patient experience I observed, the overwhelming power displayed by her physician was not uncommon. This kind of power exercised through the use of gestures, language and through the tyranny of knowledge intimidated patient after patient and fostered their dependence upon the physician.

According to Scully (Scully, 1980:92), the physicians in her study expressed a strong desire to control their patients, and they believed women to be "more malleable and submissive to authority than men." The physicians and the women patients in this study confirmed this belief except for one. H. M. was an 88-year-old housewife. She was the only assertive female patient I observed, perhaps because of her age, but even she was eventually physically overpowered by the physician.

> The patient sat on the edge of the bed. The doctor asked her relatives to leave. The patient led the conversation; interrupted the doctor to ask questions. The doctor interrupted the patient and attempted to continue the interview. The patient frequently interrupted the doctor by saying, 'Well, I was going to tell you.' The patient was articulate and knowledgeable regarding other surgeries. The doctor stared at chart while she spoke.
>
> The doctor abruptly drew curtains around the bed and moved toward the patient. 'Can you bend your neck?' Patient began bending neck. 'Okay, that's enough.' Doctor issued direct commands; patient obeyed.
>
> Patient interrupted at one point and said, 'Dr. XX is my doctor, what are you going to do?' 'I'm going to put you to sleep.' Patient insisted, 'You talk to him first.' 'We'll do what's best,' the doctor replied. 'You'll do what he says is best,' she said.
>
> Doctor began, 'Let me listen to your heart.' 'Let me turn you around.' He lifted nightgown. Patient said, 'let me take it off.' Patient appeared much more docile. Doctor stood like preacher talking with hands. Pointed to lungs, heart. Once patient encounter over, doctor opened curtains signifying encounter over and abruptly left.

At least one patient regretted not being more assertive. M. H. was a 46-year-old post-hysterectomy patient who expressed some post-operative concern about the necessity for her operation. She felt that she had been too "casually diagnosed" and now "wished (she) had gotten a second opinion." She was quick to add that "it probably wouldn't have made any difference," but she "would have felt better about it." She reflected that her operation wasn't "taken

very seriously" by the doctor, but she let him do it because "we're all so socially conditioned to be compliant."

It surprised me to hear this patient assess the situation so accurately--after the fact. But I was not surprised that she had agreed to the operation given the fact that she had been told she had a possible malignancy and that there was some urgency involved. The tumor, however, was benign.

This patient's observations are supported by Susan Schiefelbein (Schiefelbein, 1980:12) who suggests that "doctors care for male patients with cautious restraint, but treat females cavalierly, even callously--over-prescribing for them, over-operating on them." Schiefelbein reports that research by Dr. Karen Armitage and Dr. Lawrence Schneiderman of the University of California concluded that "men received more extensive work-ups than women . . . that physicians tend to taken illness more seriously in men than in women" (Schiefelbein, 1980:13). In support of this, physicians in this study were observed to be much more attentive to the male patients, have more direct eye contact with them and respond more appropriately to their questions.

Of the patients studied here, 76.2% were female. Although this supports Schiefelbein's observation that women are the consumers of most health care (Schiefelbein, 1980:12), I felt obliged to review the operating schedules for the previous 30 days to determine if the high percentage of female surgical patients was typical in this medical center. The operating schedules for one month, Monday-Friday, revealed a daily average of 40 elective surgical cases with 77.4% of these patients being female. Reviewing the weekend surgery schedules for this month, revealed that 54.6% of the patients undergoing

emergency surgical procedures were female. The speculation can be made that surgeons are more apt to elect to do surgery on females than on males, especially if one is to assume that the gender equality evident in the emergency schedules is an indication that there reasonably should be gender equality in the elective schedules.

Of the 16 female patients in this study, 14 had gynecological procedures and five of them had sterilization as either a primary or secondary surgical procedure, while two others had hysterectomies. It should be noted here that the physician population, their field of specialty, and the residency programs at a medical center greatly influence the kinds of surgical procedures performed in an institution. The medical center being studied has a high number of obstetrician-gynecologists and an active residency program. According to Scully (Scully, 1980:120-140), these two components foster what she calls the "surgical mentality" and the use of women as "teaching material" for the doctors in training. It is beyond the scope of this study to evaluate the necessity for the surgical procedures performed here. I can only serve as witness that the male patients were better prepared by the physician to give informed consent for their surgery.

The female patients in this study were typically apprehensive about their surgery, and typically their questions were ignored or not taken seriously. One patient was concerned about an abdominal scar and was answered with an inappropriate comment on "her nice tan." Most patient fears were allayed with patronizing remarks like, "Don't worry about it -- we'll take care of you" - "We'll do what's best for you" - "There's really nothing to worry about." Frequently, the patient's nervousness was a source of amusement to the physician,

and his laughter a source of embarrassment for the patient. The serious remedy used to allay anxiety was "we'll put you to sleep" or "we'll give you a sleeping pill." All of these remarks were delivered in paternalistic tones. With the middle-aged patients, these remarks were frequently accompanied by quasi-flirtatious behavior like toe tickling or leg patting.

In contrast, the male patients received a great deal of reassurance and detailed explanations of procedures. The explanations were presented in logical sequence and with what appeared to be a tacit mutual trust or male bonding. It was not uncommon for the physician to pull up a chair and sit down to talk with the male patient, while the common position for the physician talking to a female patient was from the foot of the bed. In fact, an over-abundance of time seemed to have been allocated to reassuring O.H., a 50-year-old man who was having a circumcision performed the next day. The doctor's tone of voice and his very detailed explanation indicated a sense of intimacy and concern, more than I observed with any other patient. This led me to believe that it was the nature of the surgery and a sense of male violation that the physician was reacting to, and not the patient.

Typically, the physicians were observed to exercise dual standards for courtesy. Female patients were interrupted without apology during telephone conversations, visiting hours and meal time, and they reacted as though such a breach of courtesy was acceptable because it was the doctor. One patient in the midst of a phone conversation simply said, "the doctor's here" and abruptly hung up without saying goodbye. Another patient was eating dinner, and the doctor, without warning, lifted her arm to take her pulse while she

was still holding a fork. She simply removed the fork with her other hand. Visitors were abruptly asked to leave the room, or ignored by the physician. Often the physician was observed to examine the patient or to ask personal questions in front of unidentified male visitors as was the case with one of the hysterectomy patients.

Male patients, on the other hand, were greeted with an introduction and a handshaking inquiry regarding visitors, "Is this your wife?" They were also the recipients of a great deal more formality in both the initiation and the termination of the encounter. Only one young male patient was called by his first name, while the majority of female patients were addressed by their first names or were called "dear" or "my girl." Frequently, the physician would shake hands with the male patients when interview was over, and just walk out with female patients.

It is significant to note that a large number of female patients referred to "my" doctor while all of the male patients referred to "the" doctor. The use of the possessive pronoun by women could be interpreted as their proprietory view of the physician, seeing him as their personal authority figure. The phrase was always expressed in a tone of respect and commitment as in "I'll do whatever my doctor tells me to do. He knows what's best for me." On the other hand, there were a number of female patients who did not know their doctor's name, while all the males did.

The physicians observed liberally exercised their "license to touch" the female patient without forewarning or explanation. I did not observe this with the male patients. An explanation of what was to occur always preceded the touch of the physician with male patients.

The behaviors described here support the notion espoused by Schiefelbein (Schiefelbein, 1980:12) that sexism in medicine is deeply embedded in the American culture. They also support Frankfort's (Scully, 1980:19) contention that physicians treat women like children and deny them adequate information. But the most glaring inequity confirmed by these behaviors is that male physicians do control the health of women and the female patient appears powerless to change this. The power imbalance observed here is awesome, and the individual female patients observed lack the resources to defend against it. As Scully (Scully, 1980:256) so cogently reminds us, "the control and authority of physicians is reinforced by the lack of unit among patients. There are not satisfactory individual solutions to collective problems."

Physical Symbols of Authority

The physician/patient encounter is predisposed by ubiquitous physical symbols of authority that grant the physician the right to command and imply the patient's duty to obey. The symbols are pervasive, highly visible, and magnificently effective in eliciting predictable obedient responses from patients. As if by magic, "the doctor" is able to control the behavior of the patient, by virtue of being "the doctor." The title is enough, it matters not who the doctor is, only that he is "the doctor." Significantly, a large number of patients in this study did not know the name of "the doctor" and yet were not inhibited in following his orders. This supports Rashid Bashshur's (Bashshur, 1979) observation that "the doctor" becomes

"the doctor" to everyone including his family for life (Bashshur, 1979). Patients, on the other hand, are required to wear name bands, a uniform conspicuous tagging that makes them known to all of the hospital staff. The tagging, the standardized peasant-like hospital gowns, standardized furniture, the conformity of all of the hospital articles issued to patients all serve to remind the patient that she is a non-person subservient to the staff, but especially to "the doctor."

His clothing tells her who the doctor is and that she should respond with respect. Her own lack of clothing is disarming and serves to increase the physician's power advantage. In this study, it was noted that those patients who were still in street clothes at the time of the physician/patient encounter appeared significantly more assertive than those who were disrobed. Likewise, in post-operative interviews with patients, it was noted that those patients who were dressed to go home appeared disinterested in the interview process, an indication that their patient status had now been replaced with a higher civilian status, and they were less vulnerable to the control of the hospital staff.

The white coat and the stethoscope serve as visible power symbols to identify the physician. It is most difficult for the patient to determine who the myriad of other hospital staff members are, but she knows the physician. In this study, when the white coat and stethoscope appeared, patients paid attention and obeyed commands without question and sometimes without knowing the name of the doctor or being previously acquainted with him. This supports Elizabeth Hughes and Joseph Proulx's (Hughes & Proulx, 1979:16)

notion that "you are what you wear" and that the white coat is a formidable power symbol to the patient.

The doctors in this study nearly all wore white coats. Surgical scrub suits, indicating surgeon, under the white coats were common as well. Stethoscopes were conspicuous even if not used during the examination. Most frequently, they were worn around the neck or seen protruding from pockets. Physicians in street clothes wore their stethoscopes as visible identification. Communication devices such as radio pagers were common apparel as well. Attached to outer pockets or belts, they were conspicuous as symbols of the urgent need for the physician to be available for communication, in the role of expert consultant. Pens were significantly elegant, much more than merely functional. The majority of them were gold or silver, usually gold. They appeared expensive and symbolic of wealth and status. Ordinary pens such as one might purchase for the purpose of writing alone were not seen.

Writing did not appear to be functional either. Handwriting was consistently difficult to read, often illegible. It appeared to be ritualistic more than communicative. Writing on the chart consumed a significant amount of time during the physician/patient encounter and served to protect the physician from questions. It appeared to be an avoidance technique. The physician could escape direct eye contact, or connecting with the patient on a human level. Questions from patients were frequently ignored as the physician intently wrote on the chart. Responses to patients were frequently made without looking up from the chart, or by briefly glancing up and then resuming the writing on it. The chart seemed to provide an acceptable

barrier to verbal communication between patient and physician.

It also served to remind the patient that personal information concerning her was being accounted and recorded. This information, alleged to be confidential, would be viewed by strangers to her and acknowledgement of this required a certain amount of tacit trust by her. Her legal right to confidentiality was never explained to her, nor was her legal right to have access to her own medical record. Illegibility of handwriting and medical terminology are formidable obstacles to the patient's understanding of her medical records. Having it explained to her by her physician or other health care professionals generally implies considerable trust on her part. The medical record for all practical purposes is a "secret" document to the patient yet open to the many strangers upon whom her physical well-being depends while she is a patient in the hospital.

The chart is a major symbol of the power of the physician. It is upon the chart that the physician writes his orders, the orders that control the behavior of the staff, and the orders that mandate what is done to, and for, the hospitalized patient. Hospital policy frowns upon verbal orders, and even those it accepts, must be subsequently documented and signed by the physician. Patients are frequently reminded of the power of the medical chart when they make a request and are told by the staff member that the doctor must write an order or that they must check the chart. Over and over in this study, patients made reference to the physician's written orders, and preoperative patient perceptions indicated that physicians would control what happened to the patient through their use of the written medical record.

All of these observations confirm Goffman's (Goffman, 1959:241) notion that stagecraft and props are crucial to social interaction. He suggests that keeping strategic secrets and dramatizing power are essential if one is to direct others. The physical symbols of authority used by the physicians in this study clearly influenced the social interaction and contributed to the physician's power advantage over the patient.

Language

Language has been referred to as the most important sign system in society (Berger & Luckmann, 1967:37). An understanding of language is essential for any understanding of one's situation. According to Berger and Luckmann (Berger & Luckmann, 1967:41), language forces one into patterns of conduct and sets the limits for one's interaction with others. The behavior of the physicians in this study confirmed this notion. Consistently, they used language to force patients into prescribed patterns of conduct, to keep the patient in a low state of information, and to restrict the patient's ability to use her accustomed social skills. Language used in this fashion served to keep the patient off balance and powerless in her social interaction with the physician.

Verbal and non-verbal techniques were used to accomplish these ends. Verbally, physicians were heard to habitually use esoteric terminology, technical abbreviations and jargon. "We're going to get an EKG" - "We'll start an IV in the morning" -"Your cholecystectomy is scheduled for 8 a.m." - "Have you ever been jaundiced?" - "We'll

have to intubate you." Generally, the patients would look dismayed, but few would question the physician. Usually, he would keep his eyes fixed on the medical record or rapidly move on with the interview or examination without allowing the patient the time to question or respond to his declaration. Most statements were made in a matter-of-fact tone or were issued as commands. "Take a deep breath" - "Bend your neck" - "Cough" - "Sit up" - "Lie down." Typically, patients would passively obey.

The physicians frequently spoke as plural, "We're going to . . ." - "We'll take care of you" - "We'll see how it goes" - "We'll order a sleeping pill" - as though every medical decision was the consensus of some omniscient secret committee that controls life and death and is above reproach. The plural identity also implies that the patient, as one individual, is outnumbered and overpowered by majority rule.

The physicians in this study were also observed to systematically, if not unconsciously, elicit affirmation of their political position from the patient by a form of tagging. This behavior pattern, repeatedly observed, I choose to label with the term positive solicitation. This seems to be an attempt on the part of physicians to form a kind of therapeutic partnership with patients, a partnership that functions virtually exclusively to the benefit of the physician while further reducing the range of decision-making by the patient and her power. Subtle coercion causes the patient to yield to the physician's authority. The patient has voluntarily and verbally agreed to the physician's decision under the compelling force of a symbolic environment and secreted, superior knowledge of the physician. Positive solicitation is accomplished by tagging each statement with "okay?" as

in "We'll make sure we put you to sleep, okay?" - "We're going to get an EKG, okay?" - "We'll give you your insulin at 6 a.m., okay?" -"We're going to put you on a monitor after surgery, okay?" -"Relax, we'll give you something to make you sleep, okay?"

This technique was noted in addition to the communication techniques of innuendo, strategic ambiguity, and crucial omission that have been described by Goffman (Goffman, 1959:62) as strategies to keep the patient in a low state of information.

R. M., an assertive 32-year-old white male, told the physician that his previous surgery had been performed with spinal anesthesia, and he didn't want another spinal. "What are you going to do?" he asked the physician pointedly. The physician laughed and said, "Well, we'll make sure you don't feel anything, okay?"

L. T., a 34-year-old black female, told her physician that following her previous surgery, she felt cold and shaky and it scared her, but "they just kept telling me I was okay." Her doctor said, "Well, it was probably the anesthetic, don't worry about it."

M.A. was a 32-year-old college graduate who was scheduled for a hysterectomy. She asked the doctor what kind of anesthesia he was going to use and his response was "we'll put you to sleep." She appeared to be extremely anxious about her surgery and asked, at one point, if there was a hole inside your abdomen after your uterus was removed. The physician laughed, continued to look at the chart, and said, "no, there are other organs that take its place." The patient looked dismayed, but the physician moved toward her and began listening to her heart with his stethoscope.

Moving toward the patient without explanation or forewarning

was commonly observed among this physician group. The non-verbal communication here is that the physician has a license to touch the body of the patient without the patient's permission. Typically, the patients obediently lifted hospital gowns, held themselves still and quietly waited for the physician to finish his examination. The physicians observed typically maintained faces that were expressionless during examinations and resumed writing on the medical record when the examination was completed. It was as if their findings were secret information, not to be disclosed to the patient, and intended only for the record.

Withholding information from the patient by silence signifies to the patient that the physician controls her situation. This parallels John Denton's (Denton, 1978:135) observation that the patient is made aware of the personal authority of the physician based on the knowledge he has and the patient perceives as needing.

When the physician gave information to the patient, it was usually given while he stood in an elevated position over the patient, in a preaching fashion with much pointing of the fingers or open palm of the hand. This posturing reflects the apostolic role of the physician described by Michael Balint (Anderson, 1979:260), wherein the physician sees as his duty to convert to his faith all of the ignorant and unbelieving of his patients.

Structure

The physician/patient encounter in this study took place within a structure that favored the physician and kept the patient off-balance

and in a state of helplessness. To begin with, the physician visited the patient at his convenience, unscheduled and unannounced. He initiated the encounter usually with a breach of the patient's privacy, seldom even knocking on the door. The patients were not prepared for the unanticipated interruption. The physician initiated the encounter, controlled the interview and examination, and terminated the encounter when he desired, often abruptly.

The physician/patient encounters took place in standardized hospital rooms, which resemble bedrooms. This structure signified a violation of privacy and an infringement into the intimate company of the patient and tended to enhance the power advantage of the physician. This supports Goffman's (Goffman, 1959:23) theory that the setting, furniture, decor and physical layout provide the scenery and stage props for the human activity that takes place and influences that activity accordingly.

The patients were isolated from their social support systems. Visiting by family or friends is restricted in this hospital, and those patients who had visitors at the time of the encounter were interrupted and visitors were often asked to leave the room thereby eliminating any assistance they could provide to the patient in interpreting her situation. This supports Berger and Luckmann's (Berger & Luckmann, 1967:158) notion that the patient must be segregated from her cohabitants in order for the physician to mediate her reality.

In the medical center being studied, the physicians made their rounds alone without the accompaniment of a nurse. This further compounded the invasion of privacy for the female patients and increased the power advantage for the physician.

The depersonalizing environment of the hospital appeared to foster a sense of helplessness and dependency among the patients in this study. For example, M.A., a 32-year-old female patient, was near panic because the admitting personnel had neglected to put a name tag on her wrist and she expressed the fear that something bad would happen to her as a result. During one patient interview, a loud voice issued from the speaker system and a nurse responding to the patient's signal light, said, "Can I help you?" The patient made a request for milk and was told she couldn't have any because it wasn't on her diet. When she told the voice in the box that she had milk for lunch, the reply was "Well, you shouldn't have" and the voice disappeared. The patient making the request looked visibly frustrated as a result of her exchange with the inanimate speaker box. These observations confirm the notion supported by Gonos (Gonos, 1977:858) that one can't ignore the structure within which the activity of defining takes place.

In support of Blumer's (Blumer, 1969:58) notion that all organizations represent somebody's definition of what they should be, the hospital structure here appeared to represent the physicians' definition of what it should be. The observations here confirm the idea suggested by Anderson and Helm (Anderson & Helm, 1979:267) that the interests, rules, and concerns of the organization set the tone for the physician/patient encounter in favor of the physician.

CHAPTER V: CONCLUSION & IMPLICATIONS FOR FUTURE RESEARCH

The research findings of this micro-analysis of the physician/patient encounter clearly indicate that the reality of the patient's surgical experience is socially constructed by her interaction with the physician. These findings further indicate that the social interaction between physicians and patients is dynamic and relies on variables. The observations here provide evidence that physicians and patients behave in differing ways when the variables of gender, age and class are present. The presence of these variables substantially increases the power of the physician and leads him to behave differently toward the patient. His behavior provides the signals, the symbolic universe, which is interpreted by the patient and which identifies to her how she is to respond. The physician's selective behavior then serves to construct an even greater power differential for him. It becomes evident that power begets power. The presence of these variables, especially gender, substantially decreases the patient's power and significantly limits her ability to define, negotiate and control her surgical experience.

The observations of the physician/patient encounters recorded here provide firm evidence that it is the social interaction between the two participants that creates what is real for the patient. These observations reflect a negotiation of power between the participants; the power "process" documented here is not static, it shifts and moves. The physician uses language and symbols, and the structure

within which the encounter takes place to display his power and to enhance it. His behavior, his gestures reflect different treatments for some patients, elicit different responses from some patients.

If the power of the physician is to be explained in terms of professional dominance or in terms of role theory, then the assumption could be made that the behavior of the participants and the result of the interaction would be reasonably typical for all patients. But the social interaction documented here is different with different patients, and it is this differing behavior that creates the reality for the patient. The patient's ability to negotiate this reality is shown to vary, dependent upon gender, age and class. The power base of the physician is enhanced or diminished according to these variables because he interacts differently with patients when these variables are present.

Implications for Further Study

This micro-study of the physician/patient encounter begs the question of whether patients perceive this power imbalance and seek to change it. The majority of the preoperative patients interviewed in this study expressed the belief that they would be able to control their surgical experience, in spite of their admission that the physician had decided their need for surgery, the date, time, hospital, and the type of operation. These same patients, post-operatively, in response to specific questions, expressed the belief that the physician had controlled most of what had happened to them during their surgical experience. When questioned as to who should determine what

happens to you, these patients were of the opinion that the physician should, based upon his superior knowledge. These findings indicate that patients think they can and will control their surgical experiences, but once overwhelmed by the symbolic universe of the physician and his tyranny of knowledge, they yield their authority to the physician and abdicate the personal responsibility for their health.

The physicians interviewed as part of this study indicated that the major decisions that their patients made were choice of physician, consent for surgery and the decision to follow the physician's recommended post-operative regime. They expressed the belief that the patient is responsible for the success or failure of the surgical treatment based upon the patient's compliance with the prescribed regimen.

These physician/patient interviews indicate a consistent willingness on the part of the patient to yield power to the physician and a willingness on the part of physician to accept this power and expect that the patient will be obedient, yet still responsible for the outcome. The inconsistency of responsibility for outcome without meaningful participation in treatment decisions did not seem apparent to the respondents.

Power is the major issue in health care today, according to Leroy P. Levitt, M.D., vice president for medical affairs, Mount Sinai Medical Center, Chicago. In a recent address to the American Hospital Association Society of Patient Representatives, he advocated that power be taken from the physician, the institution and the government and transferred to the patient. According to Levitt, the movement of power is difficult because "it always tends to be grabbed back." He suggests that patients abdicate power because it's easier for them,

and that physicians accept power because they have to believe in their own magic in order to make awesome decisions. His solution to this imbalance is to recommend that health care professionals work with the patient population to motivate them toward self-care and the acceptance of the responsibility for their own health (Levitt, 1980).

I agree with Dr. Levitt that power is the major issue in health care today. But I challenge his solution to the problem on the grounds that motivated patients cannot wrest power from physicians without fully understanding the power process that has been documented in this study. Equality in patient/provider relationships is an unattainable goal without careful scrutiny and analysis of the symbolic interaction of the physician/patient encounter.

This kind of research implies the need for further research to examine such things as the impact of full access to information on this encounter. A micro-analysis of the physician/patient encounter in other health care settings would assess the impact of structure on the encounter and certainly contribute new knowledge to the problem. There needs to be more research into unnecessary surgery, especially on women, and how the physician/patient encounter contributes to this problem. The research findings documented here suggest the need for future study of the physician/patient encounter to explore the mechanisms by which patients can accept the physician's definition of reality and still retain their sense of self. Future micro-analytical study of the physician/patient encounter is certain to imply the need for macro research and an analysis of medicine as a changing social system within political-economic structures..

Continued research will undoubtedly contribute to a new under-

standing of the physician/ patient relationship, and such research is necessary in order to stimulate change. The sociologist must provide this research and must act as the catalyst for change.

The rising costs of health care, the explosion of technological advances and the threat of diminishing resources are considered to be major issues in health care today. I submit that all of these issues have tremendous sociological implications. Historically, there has been a sociological lag in health care that presents itself now as an open, gaping wound that can only be healed by a radical sociological approach, one that begins with the physician/patient encounter. This approach promises to lead the way toward strategies that will encourage equality in patient/provider relationships. Without this equality, there can be no change in the health care of this nation.

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PHYSICIAN INTERVIEW GUIDE

Name_____ Date_____

1. What decisions do your patients make during their surgical course of treatment?

_____

_____

_____

2. Who do you think is responsible for the success or failure of the surgical course of treatment?

_____

_____

_____

PATIENT INTERVIEW GUIDE

Name_____ Date_____

Age_____ Sex_____ Marital Status_____ Race____ Phone_____

Educational History_____

Work History_____

Past Experience with Hospitals/Physicians_____

Preoperative Interview

1. Who is your doctor? _____

2. What kind of surgery are you having?

   _____

3. Who decided that you needed surgery?_____

4. Did you choose the:

   Date of Surgery?_____

   Time of Surgery?_____

   Hospital?_____

   Doctor?_____

   Operation Type?_____

5. How long will you be in the hospital?_____

6. Do you feel you have any control over what will happen to you in the hospital?

   _____

7. Who do you think will determine most of what will happen to you while you're in the hospital?

   _____

   Why is this true?_____

   _____

Postoperative Interview

1. Did your operation go as you expected?

_____

2. Who decided when you should:

Get out of bed?_____

Eat?_____

Sleep?_____

Get pain medication?_____

Have visitors?_____

Go back to work?_____

Go home?_____

Have sex?_____

3. Do you feel like you had any control over what has happened to you in the hospital?

_____

4. Who do you think determined most of what happened to you?

_____

5. Who do you think should determine most of what happens to you in the hospital?

_____

The Social Construction of the Patient's Reality